REMOTE AREA MEDICAL®

Volunteer Registration

PLEASE PRINT CLEARLY

NAME_____ PROFESSION _____

ADDRESS_____ PHONE (work)_____

_____ PHONE (home)_____

Expedition #_____ EMAIL: _____

Date(s) 9/17-9/19 2010 Location: **Freedom Hall Louisville Ky** Country **USA**

JOB ASSIGNMENT (if known): _____

SHIFTS YOU ARE VOLUNTEERING (circle all that apply):\

Fri. 9/17 6am - 12 noon	**Fri 9/17 12 noon - 6 pm**
Sat. 9/18 6am – 12 noon	**Sat. 9/18 12 noon – 6 pm**
Sun. 9/19 6am – 12 noon	**Sun. 9/19 12 noon – 4 pm**

Tell us the best way to contact you: _____

Housing Needed: Yes ___ No ____ Dates Needed: Thursday 9/16 Friday 9/17 and/or Saturday 9/18

What size t-shirt? ___Small ___Medium ____Large ____X-Large ____XX-Large ___XXX-Large

ALL VOLUNTEERS MUST CHECK IN AND OUT DAILY AT VOLUNTEER REGISTRATION TABLE

Compliance Statement

I hereby attest that my license/certificate is not suspended or revoked pursuant to disciplinary proceedings in any jurisdiction. **A COPY OF MY CURRENT STATE LICENSE OR CERTIFICATE AND DEA# (where applicable) ARE ATTACHED HERETO.**

Confidentiality Statement

I understand that while I am participating as a registered volunteer at the Remote Area Medical® Clinic, it is mandatory that I maintain complete privacy and confidentiality of all patients. This pertains to all present and future written and verbal communications referring to any Remote Area Medical® Clinic patient. I also understand that unless I am obtaining information strictly for patient registration, I **DO NOT ASK** a patient any questions regarding medical insurance coverage, MCR or MCD. With my signature on the line below, I acknowledge that I have read, understand, and agree to adhere to this policy of confidentiality for the Remote Area Medical® Clinic.

Release and Indemnification

I hereby release and indemnify Remote Area Medical®, a non-profit organization, and all its respective officers, directors, agents, contractors, heirs, successors and assigns, from prosecution or presentation of any claim for bodily injury or death or for property loss or damage incurred in connection with this Remote Area Medical® expedition or related activities.

I fully understand that I am volunteering at my own risk and that due to my occupational/other possible exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection or other blood borne pathogens. I understand if I do not have the HBV vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If, in the future, I want to be vaccinated with Hepatitis B vaccine, I can acquire the vaccination at my own expense.

_____ _____

Printed Name **Signature**

_____

State(s) of Licensure(s)/Certification(s)

Remote Area Medical® is a 501(c)(3) medical relief charity located at 1834 Beech Street, Knoxville, TN 37920, 865-579-1530

Please return form and copy of current license (if applicable) to: **Please return form and copy of current license (if applicable) to**: **Megan Allen, Kentucky Board of Dentistry, 312 Whittington Parkway Suite 101, Louisville Ky. 40222, or fax the form to (502-429-7282**. If you have questions, please call Brian Bishop (502)-429-7280 or e-mail: **megan.allen@ky.gov or briank.bishop@ky.gov or ramkentucky@hotmail.com**